Re-Engineering Healthcare Integration Programs (REHIP)

Planning for Primary Care & Psychological Health Care Integration

A DCoE-Funded Tri-Service Demonstration Project

Report Documentation Page

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Overview

- Purpose
- Background
- Approach
- Way Forward

Purpose

- Optimize Psychological Health* services in military Primary Care
- Implement emerging DoD policy and intent across the MHS

Prevalence

- 80% with a behavioral health (BH) disorder visit primary care (PC) at least once a year[1]
- 50% of all BH disorders are treated in PC[2]
- 48% of the appointments for all psychotropic agents are with a non-psychiatric PC provider[3]

1. Narrow et al., Arch Gen Psychiatry. 1993;50:5-107.
2. Kessler et al., NEJM. 2005;352:2515-23.
3. Pincus et al., JAMA. 1998;279:526-531.

Unmet Need

- 67% with a BH disorder do not get BH treatment[1]
- 30-50% of referrals from PC to outpatient BH clinic don't make 1st appt[2,3]
- 50% of primary care managers (PCMs), can only sometimes, rarely or never get high-quality behavioral health referrals for patients[4]

1. Kessler et al., NEJM. 2005;352:515-23.
2. Fisher & Ransom, Arch Intern Med. 1997;6:324-333.
3. Hoge et al., JAMA. 2006;95:1023-1032.
4. Trude & Stoddard, J Gen Intern Med. 2003;18:442-449.

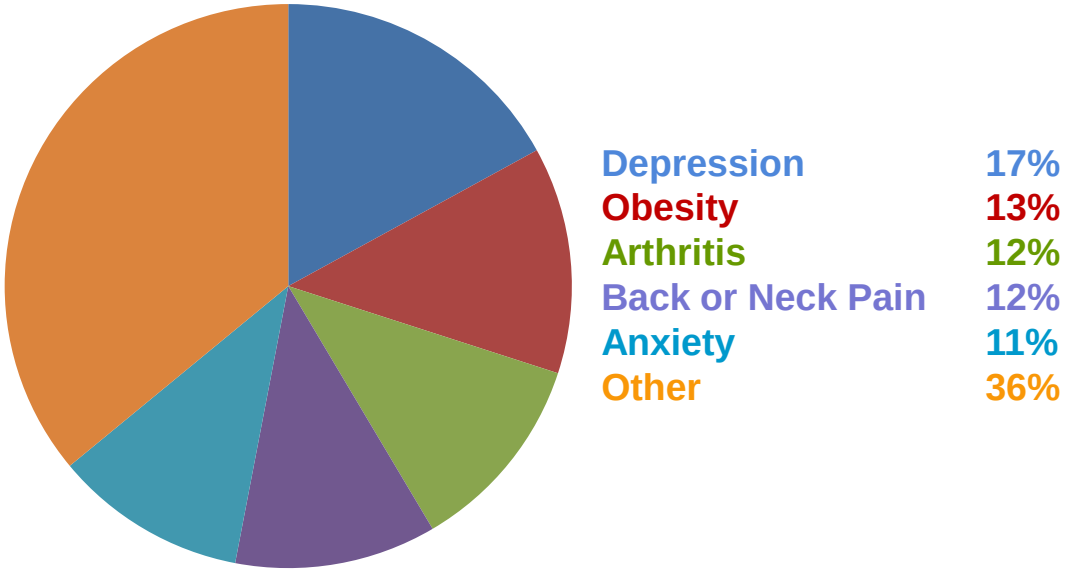
Unmet Need

- Health Care Survey of DoD Beneficiaries (2008):
  - *~35% of military health system beneficiaries report difficulties accessing BH care*
  - *~70% of family members report challenges accessing urgent BH care*

MHS Beneficiaries' Access to Behavioral Health Care Issue Brief Health Care Survey of DoD Beneficiaries (HCSDB) July 2008

Cost of Unmet Need

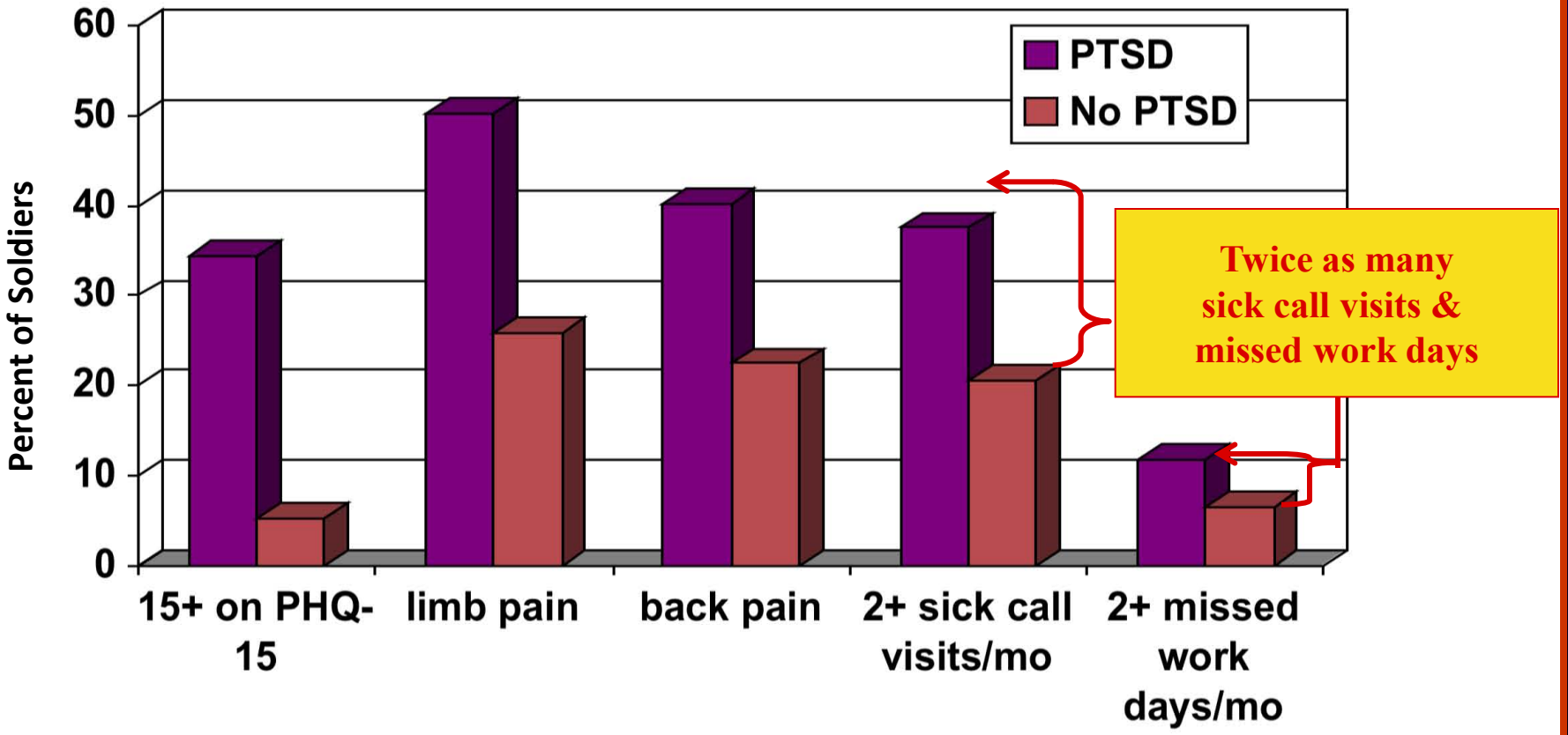
- BH conditions account for ½ as many disability days as “all” physical conditions[1]
- Annual medical expense for chronic medical + BH care is 46% greater than for chronic medical care alone[2]
- Top 5 conditions driving overall health costs (cost = reduced work productivity + medical costs + pharmacy costs)[3]



1. Merikangas et al., Arch Gen Psychiatry. 2007;64:1180-1188
2. Original source data is the U.S. Dept of HHS the 2002 and 2003 MEPS
3. Loeppke et al., J Occup Environ Med. 2009;51:411-428.

Potential for Offset: Service Use & Missed Work

2,863 Iraq War returnees one-year post-deployment



Hoge et al, Am J Psychiatr, 2007

Lower Cost When Treated

- Medical cost ↓17% for those receiving BH tx[1]
  - *Controls who did not get BH tx cost ↑12.3%*
- Depression tx in PC for those with diabetes[2]
  - *$896 lower total health care cost over 24 months*
- Depression treatment in PC[3]
  - *$3,300 lower total health care cost over 48 months*

1. Chiles et al., Clinical Psychology. 1999;6:204–220.
2. Katon et al., Diabetes Care. 2006;29:265-270.
3. Unützer et al., American Journal of Managed Care 2008;14:95-100.

Lower Cost When Treated

Buncombe County Health Center

Decrease in Health Care Costs

- All health care-overall reduction---$66 PMPM
- Mental health care reduction---$295 PMPM
- In-patient cost reduction---$1455 PMPM
- High users of health care decreased---$435 PMPM

Lower Cost When Treated

Cherokee Health System

After At Least 1 Primary Care Behavioral Health Visit

- *28% ↓ in medical use for Medicaid patients*
- *20% ↓ in medical use for commercially-insured patients*
- *27% ↓ in outpatient psychiatry visits*
- *34% ↓ in out patient psychotherapy sessions*

Cherokee Data vs. Other Regional Providers

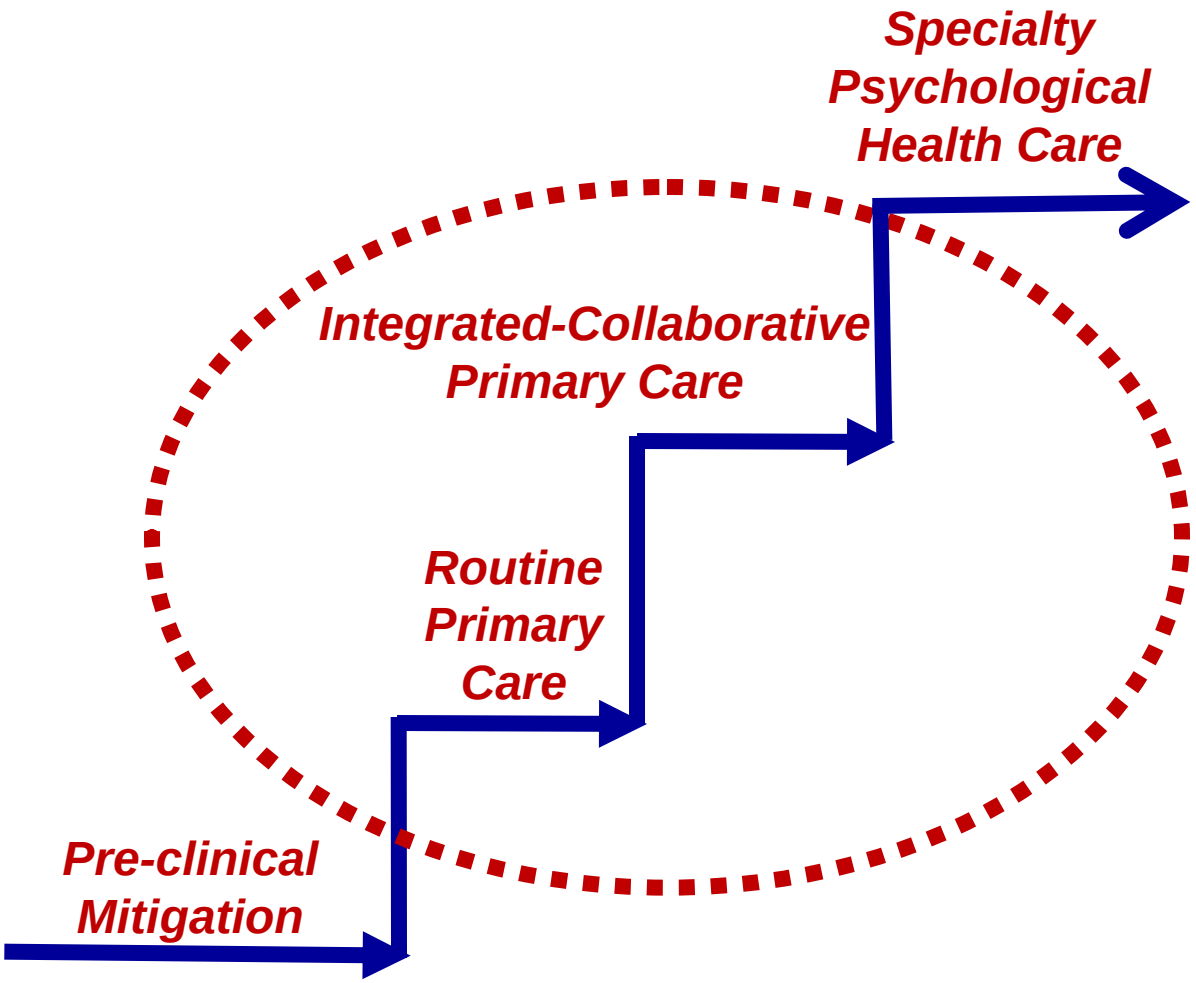
- *All Lower specialist utilization*
- *Lower ER utilization*
- *Lower hospital admissions*
- *Lower overall costs per enrollee*

Better Outcomes

- Quantitative & qualitative reviews[1-4]
  - *Depression*[1-4]
  - *Panic Disorder*[1,2]
- Other Studies[5]
  - *Tobacco*
  - *Alcohol Misuse*
  - *Diabetes, IBS, Primary Insomnia*
  - *Chronic Pain, Somatic Complaints*

1. Butler et al., AHRQ Publication No. 09- E003. Rockville, MD. AHRQ. 2008.
2. Craven et al., Canadian Journal of Psychiatry. 2006;51:1S-72S.
3. Gilbody et al., British Journal of Psychiatry, 2006;189:484-493.
4. Williams et al., General Hospital Psychiatry, 2007; 29:91-116.
5. Hunter et al., Integrated Behavioral Health in Primary Care: APA, 2009.

Stepped Care for Population Health Services



Adapted from Engel et al 2004. Can we prevent a Second Gulf War Syndrome? Advances in Psychosomatic Medicine

Models of Care

- **Care Management Model**
  - *Typically focused on a discrete clinical problem*
  - *Specific pathways to systematically address how BH problems are managed in PC*
  - *PC providers & care managers share information*
  - *Systematic interface with the outpatient mental health clinic*

Models of Care

- **Primary Care Behavioral Health Model**
  - *Focused on all enrolled patients*
  - *Embedded Behavioral Health Consultant (BHC)with PC team*
  - *BHCs & PCMs share patient information*
  - *Brings a team-based management approach*
  - *Helps team improve BH assessment & intervention*
  - *Sees patients in 15-30 minute appointments*
  - *Same day as well as scheduled appointment availability*
  - *Focuses on full range of BH & health behavior change*

REHIP: Blending Models

RESPECT-Mil Systems Continuity Method

- Reduces drop out
- Maximizes clinical efficiency
- Tracks to remission or referral to another level of care

GOALS TO IMPROVE

- Continuity of Care
- Access to Specialty Care
- Strong Empirical Support
- Clinical Feasibility & Efficiency
- Behavioral Medicine Approaches
- Implements DoD/VA Guidelines

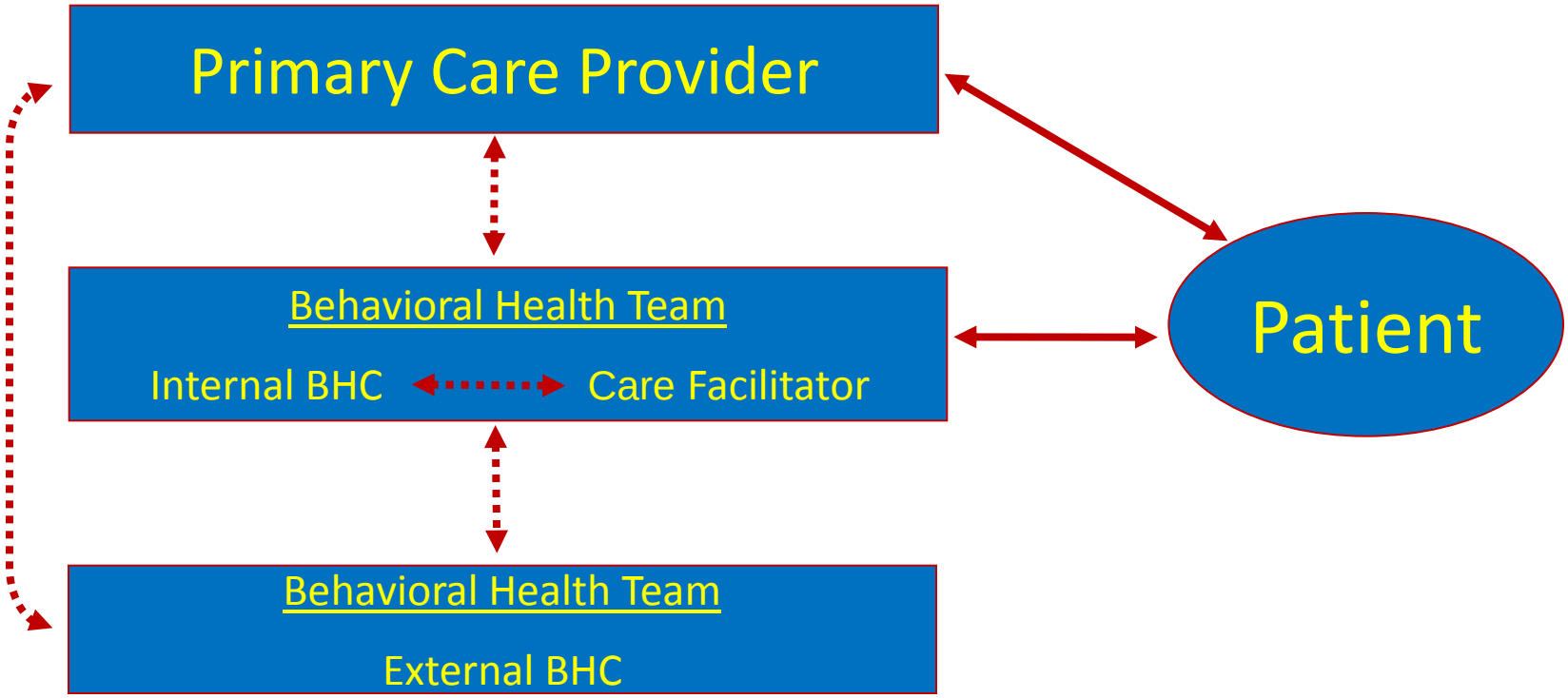
BHOP

Embedded Specialist Method

- PCM has expert consultants on team
- Improves PC access to psychosocial treatment
- Addresses broad range of PH problems

Re-Engineering Health Care Integration Programs

Primary Care Medical Home ~ A Prepared Interdisciplinary Practice



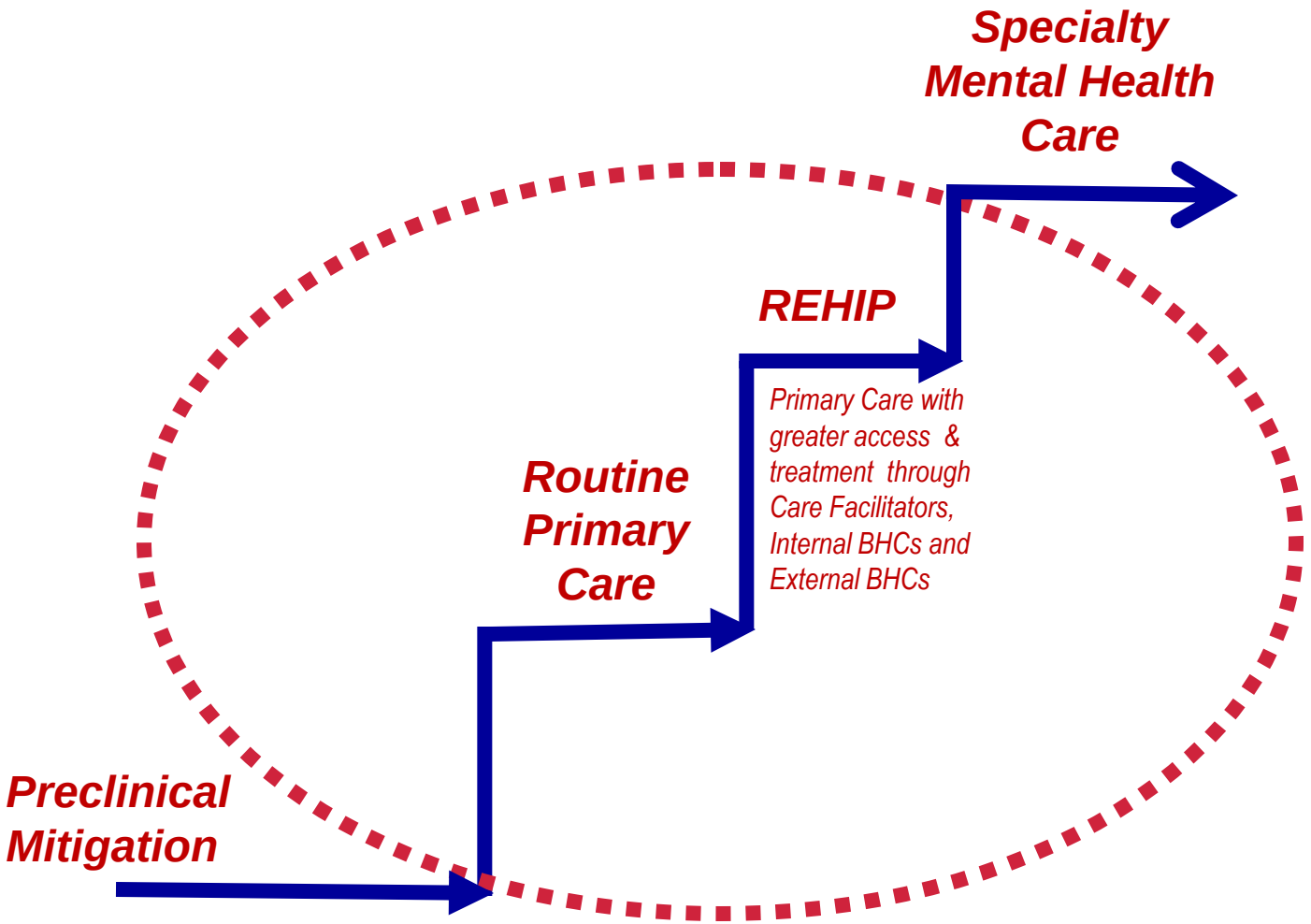
REHIP Proposal

- **A Tri-Service demonstration project and evaluation**
  - Operationalizes guidance from Mental Health Integration Working Group & Office of the Chief Medical Officer (TMA)
- **Marries components from existing programs into one consistent "best practice"**
  - Implements collaborative "team-medicine" approach
  - Enhances access to intensive, focused therapeutic intervention and collaborative treatment planning for a range of issues
  - Improves recognition, management, and continuity of care for depression and PTSD
- **Six sites (site=base/post), two per Service**

REHIP Components

- Approach is codified into manuals for Primary Care Provider, Care Facilitator, and Behavioral Health Consultants.
- Screening, assessment & treatment for all adult beneficiaries
- Universal screening for depression & PTSD for improved recognition & early intervention.
- Centralized training, evaluation with program development and management.
- Action Officers in each Service that will coordinate and communicate with site Champions and the REHIP Implementation Cell (RIC)

Why REHIP?



Adapted from Engel et al 2004. Can we prevent a Second Gulf War Syndrome? Advances in Pyschosomatic Medicine

REHIP Clinic Staffing

- One Primary Care Champion per site (Team Leader)
- One Behavioral Health Champion
- Internal Behavioral Health Consultants
- External Behavioral Health Consultants
- Nurse Care Facilitators - One or more FTE per for clinic
- Administrators

REHIP Implementation Cell (RIC)

Distinctively…

- Multidisciplinary
- Tri-Service
- Experienced
- Fully Funded

Providing…

- Training and Support
- Manuals and Tools
- A Data Repository
- Evaluation

REHIP Summary

- A Tri-Service Demonstration
- Evidence-based
- Improves population access
- Expands available care options
- Maximizes continuity of care
- Consistent with Patient-Centered Medical Home

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